TALOGA PUBLIC SCHOOLS
School year 2017-2018

HEALTH HISTORY AND MEDICAL TREATMENT CONSENT FORM

**Please give all information requested as completely as possible, N/A-if doesn't apply
##If information changes during this school year, please notify the office.
THIS IS A TWO PAGE DOCUMENT. PLEASE COMPLETE BOTH PAGES

Personal Information

Student's Name ________________________________ Today's Date __________
Male Female (circle) (First) (Middle) (Last) Name goes by __________
Grade ______ Date of Birth __________ Social Security Number __________
Mother __________ Father __________ Guardian __________
Home Phone __________ Work Phone __________ Cell/Mssg. Phone __________
Address ________________________________
Street or P.O.Box City, State Zip Code
E-Mail ________________________________
Insurance/Medicaid/None (circle) Insurance Company __________

Medical Information

Doctor/Nurse Practitioner/PA Name __________ Office Location __________
Allergies (food, medication, pets, environment) __________
Glasses/contacts? Date of: Last Eye Exam __________ Last Dental Exam __________ Last Tetanus Shot __________
Illnesses/Hospitalizations (include dates) __________
Medical problems requiring monitoring (ADHD, asthma, behavioral, diabetes, seizures, __________

HEALTH SCREENINGS

Throughout the year, any of the following screenings may be provided to the students of Taloga Schools:
Vision, Hearing, Dental Hygiene, Temperature
There will be NO COST for these screenings. Parents will be notified of abnormal findings.
Written notification must be provided by the parent/guardian if you do not consent to any of these screenings.

CONSENT FOR MEDICAL TREATMENT

In the event of illness or injury, every attempt will be made to contact you to inform you of your child's condition, and to obtain your directions and consent for treatment. However, if you are unable to be reached, please provide the names and current phone numbers of two people who may be authorized to pick up your child or give consent for treatment by school personnel in your absence.

Name __________ Relationship __________ Phone __________
Name __________ Relationship __________ Phone __________
***Only the people listed above will be permitted to pick up your child without consent from you.

Please initial the choices below that indicate how care should be given to your child if injury or illness occurs.
(initial)_____ I hereby authorize Dr. __________ or any other physician, surgeon or dentist to administer any emergency treatment, procedure or medicine deemed necessary or advisable. In case of an emergency occurring while the student is away from the immediate vicinity, I authorize officials to secure the use of an ambulance, if necessary, for transporting my child to the hospital. I further agree to pay for the hospital, doctors and ambulance service and for all services rendered to my child.
(initial)_____ I hereby authorize designated school personnel to provide first aid or medical treatment, as indicated, to my child in the event of an injury occurring during school hours or school functions.
~~(initial)_____ **I do not** consent to the above medical care for my child. Please give specific instructions for what~~ you wish to be done if your child becomes seriously ill or injured and we are unable to reach you.

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Parent/Guardian Signature X __________ **Date signed** __________